State of New Jersey

Jon S. Corzine
Governor

OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF LAW AND PUBLIC SAFETY
STATE ATHLETIC CONTROL BOARD
P.O. BOX 180
TRENTON, NJ 08625-0180

Stuart Rabner
Attorney General

Tony Orlando
Chairman

Steven Katz
Member

Dennis McDonough
Member

Larry Hazzard, Jr.
Commissioner

TO: PROFESSIONAL COMBATIVE SPORTS CONTESTANTS

FM: Larry Hazzard, Sr.
Commissioner

RE: NEW JERSEY PROFESSIONAL BOXER/KICKBOXER/MIXED MARTIAL ARTS LICENSE APPLICATION

Enclosed are the annual requirements for application as a licensed professional boxer/kickboxer/mixed martial arts contestant in the State of New Jersey.

To be licensed as a **Boxer/Kickboxer/Mixed Martial Arts** contestant, you must submit the following to this office:

1. Completed Application Form
2. Completed Physical Examination - Boxer Form (dated within 6 months of licensure/event)
3. Complete HIV exam (not required to obtain a license, however, to compete in an event, test must be dated within 6 months of event)
4. Complete HEP B Surface AG testing & HEP C AB (not required to obtain a license, however, to compete in an event, test must be dated within 6 months of event)
5. Complete Blood Count (CBC) and Bleeding & Coagulation (PT/PTT Pro-time)
6. Original EKG report, read by a physician (dated within 6 months of licensure/event)
7. Original CT/MRI Brain SCAN report (without contrast), read by a physician (dated within 3 years of licensure/event)
8. Original EYE examination by an ophthalmologist - opthalmological dilation (dated within 6 months of licensure/event)

9. Serum Pregnancy test (dated within 30 days of licensure/event & repeated within 30 days of each event)
10. Annual Physical/Clinical Gynecological & Breast Exam for women (dated within 30 days of licensure/event)
11. Check or money order in the amount of $5.00, payable to the State Athletic Control Board.

NOTE: Proof of medical testing must be provided through **"ORIGINAL DOCUMENTS"** indicating date of test, location of test and identification of the doctor. The date, location and name of doctor who reviews the medical test results must also be provided.

IMPORTANT: The New Jersey Boxer License that you receive will be effective for **Twelve (12)** months from date of issue.

To reduce the costs for individual tests, the Board has obtained an agreement from Millville Hospital, near Atlantic City, to provide medical testing at specific rates. For further information contact Millville Hospital at 856-451-8700, ext. 54835 and ask for Joan Pierce of South Jersey Medical Systems.

Applicants are reminded: You are subjected to the requirements of the State Athletic Control Board rules, provided by Chapter 46 of the New Jersey's Administrative Code.

Take note of "Subchapter 5 Boxers" under the rules, and the subject of Boxer-Manager contracts within New Jersey. Submitting a valid Boxer-Manager contract to this office may avoid possible disputes or court action.

Important: Effective immediately all boxer-manager contracts shall be executed and signed in the presence of the commissioner. In order to have the contract recognized, please schedule an appointment with the commissioner.

If there are any questions regarding your application, please contact this office at 609-292-0317.

L.H.

LH/tg
Enclosure
03.2005

PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO N.J.S.A.C.B. *
*****NO CASH!!*****

NEW JERSEY STATE ATHLETIC CONTROL BOARD
LICENSE APPLICATION

P. O. Box 180
Trenton, New Jersey 08625-0180
Telephone: (609)292-0317 Fax: (609)292-3756

Check (✓) or Circle Type/s of License

CONTESTANT	MANAGER	SECOND	
❒ Boxer $5	❒ Boxing $25	❒ Boxing $25	❒ Announcer $25
❒ Kickboxer $5	❒ Kickboxing $25	❒ Kickboxing $25	❒ Timekeeper $25
❒ Mixed Martial Artist $5	❒ Mixed Martial Arts $25	❒ Mixed Martial Arts $25	❒ Other $____
			_____

REFEREE	JUDGE	PROMOTER	MATCHMAKER
❒ Boxing $75	❒ Boxing $75	❒ Boxing $300	❒ Boxing $100
❒ Kickboxing $75	❒ Kickboxing $75	❒ Kickboxing $300	❒ Kickboxing $100
❒ Mixed Martial Arts $75	❒ Mixed Martial Arts $75	❒ Mixed Martial Arts $300	❒ Mixed Martial Arts $100

SECTION I (All Applicants) - Please Print

NAME: AKA or ALIAS (Other Names Used):

ADDRESS: CITY: STATE: ZIP: COUNTRY:

MAILING ADDRESS **(complete if different from above)** CITY: STATE: ZIP: COUNTRY:

TELEPHONE (Residence): ( ) TELEPHONE (Business): ( ) FAX# ( ) E-MAIL ADDRESS:

DATE OF BIRTH: SOCIAL SECURITY#: HEIGHT: WEIGHT:

SEX: ❒ MALE ❒ FEMALE CITIZENSHIP: PLACE OF BIRTH:

Have you ever been convicted of a crime? If yes, explain: ❒ YES ❒ NO

Are you presently on any suspension list? If yes, explain: ❒ YES ❒ NO

Have you ever been disqualified in any contest or disciplined for your actions during a contest? ❒ YES ❒ NO
If yes, explain:

Has any license you've held been revoked? If yes, please explain: ❒ YES ❒ NO

List all other Athletic Commissions in which you are licensed:

SECTION II (Boxer's, Kickboxer's & Mixed Martial Artist Only) - Please Print

Have you ever been hospitalized due to an injury suffered in any contest? If yes, explain: ❒ YES ❒ NO

Do you have any current medical conditions? If yes, please explain: ❒ YES ❒ NO

Do you have a manager? If yes, provide name, address & telephone number: ❒ YES ❒ NO

Name: **Address:** **Telephone No: (_____)**

Have you had amateur experience**?** If yes, complete the following questions: ❒ YES ❒ NO

Amateur Record: _____ **Number of Fights:** _____

Submission Grappling Record:_____

Name of Gym or Club where you trained**:** _____

Name and Telephone Number of Trainer or Manager:

Name:_____ **Telephone Number:** __(_____)_____

SECTION III (Manager's & Second's Only) Please Print

List names of boxers which you currently manage/second:

Do you know of any medical conditions which your boxers currently have?: If yes, please explain ❒ YES ❒ NO

I THE UNDERSIGNED HEREBY DECLARE THAT I HAVE READ THIS APPLICATION AND THAT ALL THE ANSWERS TO THE QUESTIONS ARE TRUE AND COMPLETE. I UNDERSTAND THAT ANY MISREPRESENTATION OR FAILURE TO ANSWER SHALL CONSTITUTE GROUNDS FOR LICENSE REVOCATION AND OR OTHER APPLICABLE LEGAL PENALTIES.

I ALSO UNDERSTAND THAT BY SIGNING THIS APPLICATION THAT I AM AUTHORIZING THE STATE ATHLETIC CONTROL BOARD TO CONDUCT A FULL INVESTIGATION INTO MY BACKGROUND AND ACTIVITIES. I UNDERSTAND THAT THE OFFICE OF THE ATTORNEY GENERAL AND THE NEW JERSEY STATE POLICE MAY PARTICIPATE IN THIS BACKGROUND INVESTIGATION.

TO ALL COURTS, PROBATION DEPARTMENTS, SELECTIVE BOARDS, EMPLOYERS, EDUCATIONAL INSTITUTIONS, FINANCIAL INSTITUTIONS AND ALL GOVERNMENT AGENCIES, FEDERAL, STATE AND LOCAL, WITHOUT EXCEPTION, BOTH FOREIGN AND DOMESTIC. I HAVE APPLIED FOR A LICENSE WITH THE STATE ATHLETIC CONTROL BOARD AND FOR THE PURPOSE OF THIS APPLICATION, YOU ARE HEREBY AUTHORIZED TO RELEASE ANY AND ALL INFORMATION PERTAINING TO ME, DOCUMENTARY OR OTHERWISE, AS REQUESTED BY ANY APPROPRIATE EMPLOYEE, AGENT OR REPRESENTATIVE OF THE STATE ATHLETIC CONTROL BOARD, THE OFFICE OF THE ATTORNEY GENERAL OR THE NEW JERSEY STATE POLICE.

I THE UNDERSIGNED STATE THAT A PHOTOSTATIC COPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

FURTHER, I AM AWARE AND AGREE THAT MY SIGNATURE CONSTITUTES A WAIVER OF LIABILITY AS TO THE STATE OF NEW JERSEY AND ITS INSTRUMENTALITIES AND AGENTS FOR ANY DAMAGES RESULTING IN DISCLOSURE OR PUBLICATION IN ANY MANNER, OTHER THAN A WILLFULLY UNLAWFUL DISCLOSURE OR PUBLICATION, OF ANY MATERIAL OR INFORMATION ACQUIRED DURING THE LICENSURE CONSIDERATION PROCESS OR DURING ANY INVESTIGATIONS, INQUIRY OR HEARING.

I HEREBY AUTHORIZE THE RELEASE OF ANY CRIMINAL HISTORY RECORD INFORMATION TO THIS AGENCY ONLY FOR THE EXPRESS PURPOSE OF PROCESSING MY APPLICATION FOR A LICENSE. THE AUTHORITY TO REQUEST CRIMINAL INFORMATION IS SET FOR IN *N.J.S.A. 5:2A-15.*

I UNDERSTAND THAT THE DISCLOSURE OF MY SOCIAL SECURITY NUMBER ON THIS APPLICATION IS VOLUNTARY AND THAT IT WILL ONLY BE USED FOR PURPOSES OF PROCESSING MY APPLICATION.

DATE:_____ SIGNATURE:_____

REV: 01.12.06

State of New Jersey
Department of Law & Public Safety
State Atlethic Control Board

CHILD SUPPORT QUESTIONS

Please certify, under penalty of perjury, the following:

	YES	NO
1. Do you currently have a chid-support obilgation?	☐	☐
a. If "YES", are you in arrears in payment of said obilgation?	☐	☐
b. If "YES", does the arrearage match or exceed the total amount payable for the past six months?	☐	☐
2. Have you failed to provide any court-ordered health insurance coverage during the past six months?	☐	☐
3. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding?	☐	☐
4. Are you the subject of a child-support-related arrest warrant?	☐	☐

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "YES" to any of the questions numbered 1a through 4 will result in a denial of licensure. Furthermore, any false cerification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure.

Applicant's name (please print)	Applicant's signature	Date

***Social Security Number:** _____ - _____ - _____

You **must** disclose your Social Security Number for the reasons stated below. Failure to do so may result in a denial of licensure or license renewal.

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COMMUNICABLE BODILY FLUID VIRUS HIGHT-RISK QUESTIONNAIRE

1. Do you have any immediate family members who have HIV, Hepatitis B or C? ❑ **Yes** ❑ **No**
   If yes, please provide detail.
   _____
2. Have you received a transfusion of blood or blood components? ❑ **Yes** ❑ **No**
   If yes, specify date, location, reason.
   _____
3. Have you had surgery requiring blood products? ❑ **Yes** ❑ **No**
   If yes, specify date, location, reason.
   _____
4. Have you used injectable drugs? ❑ **Yes** ❑ **No** If yes, specify date of most recent injection.

   _____
5. Have you been sexually active with an individual who has HIV, Hepatitis B or C? ❑ **Yes** ❑ **No**
6. Have you engaged in unprotected sex? ❑ **Yes** ❑ **No**
7. Have you had sex with an injectable drug user? ❑ **Yes** ❑ **No**
   If yes to questions 5 through 7, please provide most recent date of such activity.
   _____
8. Have you worked in a health care or laboratory setting? ❑ **Yes** ❑ **No** If yes, please provide appropriate dates.

   _____
9. Have you been imprisoned or worked in a prison or any type of correctional facility? ❑ **Yes** ❑ **No**
   If yes, please provide appropriate dates.
   _____
10. Do you have any tattoos or body piercing? ❑ **Yes** ❑ **No** If yes, when was the most recent one obtained.

    _____
11. Do you have any reason to believe that you may have contracted HIV or Hepatitis B or C at any time?
    ❑ **Yes** ❑ **No** If yes, explain:

    _____

Contestant's Name: _____ **Contestant's Signature:** _____

Date: ___/____/____

NEW JERSEY STATE ATHLETIC CONTROL BOARD
P.O. BOX 180 TRENTON NJ 08625
PHONE 609-292-0317 FAX 609-292-3756
PROFESSIONAL COMBATIVE SPORTS CONTESTANT PHYSICAL EXAMINATION

Contestant Name: _____

Street Address:_____ City_____ State_____ Zip_____

Phone: _____ Date of Birth:_____

I certify that I have examined the above named contestant on _____ and have found him/her to be medically cleared to engage in an professional combative sport competition.

Physician Name (printed): _____
Physician Signature:_____

Physician Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Physician's License Number:_____

CONTESTANT EXAMINATION:

Height:_____
Weight: _____
Sex:_____

Blood Pressure: _____
Pulse: _____

Temperature: _____

Blood Type: _____

Allergies:
_____
_____

Medications:

_____
_____

Any enlarged glands:

_____

Ears - Otoscopy:
_____

Mouth Pharynx:
_____

Lungs:
_____

Heart:

Must include check for Murmurs:

_____

_____

_____

Abdomen:

Abdominal Palpation:

Hernias:

Enlargement of Liver:

Enlargement of Spleen:

Testis:
_____

NEUROLOGICAL:

Knee Jerk:
_____

Babinski:
_____

Rhomberg:
_____

Finger to nose:
_____

Gait:
_____

Brudzinski:

_____

Cranial Nerves:

_____

Bicep Jerks:
_____

UPPER EXTREMITIES:

Hands:
_____
_____

Wrist:
_____
_____

Elbows:
_____
_____

Shoulder:
_____
_____

Lower Extremities:
_____
_____

Skin:

Open or Superlative lesions:

Rashes:

Any unhealed cuts:

_____
_____
_____

Any indications of active renal disease:
_____

PHYSICAL HISTORY:

Chest Pains:
_____
_____

Fainting Spells:
_____
_____

Chest Palpitations:
_____

Hemoptysis or Vomiting of Blood
_____

Shortness of Breath
_____

Frequent Headaches:
_____

Convulsions:
_____

Past Head Injury or Concussions:
_____
_____

Operations:
_____
_____

Diabetes:
_____

Unconsciousness from training or competing:
_____

FOR WOMEN:

Pregnancy Test:
_____

Breast Exam:
_____

Gynecological Exam:
_____

PHYSICIAN COMMENTS:
_____

_____

_____

_____

PHYSICAL HISTORY(CONTNUED):

Unconsciousness from any other sport or for any other reason:
_____
_____

Sickle Cell Disease:

_____

Infectious Disease:

_____

DILATED EYE EXAMINATION MUST BE PERFORMED BY AN OPHTHALMOLOGIST

EYES RIGHT LEFT

Distant Vision:

Light Reflex:

Accommodation Reflex:

Fundi:

Cataracts:

Wears Contact Lenses:_____

Has patient had blurred vision?
If yes, please detail:_____

Has patient had surgical procedures done to his/her eyes or the tissues around the eye?
If yes, please detail:_____

Has applicant ever had a retinal tear, retinal detachment, glaucoma, aphakia, or dislocated lens?
If yes, please detail:_____

Does patient have different size pupils?
If yes, please explain:_____

I certify that I have examined the above contestant on _____ and have found nothing in his//her eye examination which would prohibit engaging in an professional combative sport competition.

Ophthalmologist Name (printed)_____
Ophthalmologist Signature:_____

Ophthalmologist Address: _____ City: _____ State: _____
Zip: _____
Office Phone: _____ Physician's License Number:_____

I hereby declare that the foregoing information is true, complete and correct. I understand that any misrepresentation may subject me to license revocation and applicable legal penalties.

Contestant's Signature:_____ Date:_____

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LARRY HAZZARD, SR.
Commissioner

TO: All Boxers and Mixed Martial Artists

FROM: Larry Hazzard, Sr., Commissioner, SACB

SUBJECT: Pre-Fight Medicals Questionnaire

DATE: March 28, 2006

Please be advised that all medical questions appearing on SACB pre-fight questionnaires are designed to ascertain information relative to any existing medical condition you may be presently experiencing. If you are currently taking prescribed medication and/or have recently been treated for any injury, you should answer "yes" to the question. Answering "yes" does not automatically mean that you will be disqualified from participating, however, if you fail to honestly disclose the information to us prior to your participation, and it is revealed during the post-fight physical examination or through the drug testing process you will be suspended.

LH/tg
c: Sylvester Cuyler
Nicholas Lembo
Ringside Physicians